FOR OFFICE USE ONLY
Radiologic Tech Checklist
☐ Endorsement ☐ Examination
☐ Grad Status
☐ App. & Fee
☐ Date:_____ Check_____
☐ Photo
☐ Transcript or ARRT Letter
☐ Exam Results from ARRT
☐ Resume
☐ Lic. Verification from other States
☐ SSN Verification

FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
Grad License Number:
Issue Date:
Signature of Board Administrator
ID#:
Receipt #:

Rhode Island
Board of Radiologic Technology

Room 205
3 Capitol Hill
Providence, RI 02908-5097

License # _____

Name _____

Instructions and Application For
License As A

☐ Radiographer

☐ Nuclear Medicine Technologist

☐ Radiation Therapist

☐ **Endorsement**

☐ **Examination**

Graduate Status ☐ **Yes** ☐ **No**

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-2837 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

Revised 10/24/2007 jcp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Licensure Requirements

- A non-refundable application fee of **$90.00**.
- Recent 2x2 photograph of yourself
- A chronological resume of experience
- Official transcripts from an accredited school indicating successful completion of a training program as a radiographer, a radiation therapist or a nuclear medicine technologist**
- Score/verification of completion of the national certification examination given by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certifiation Board (NMTCB).

** In lieu of submittal of an official transcript, an applicant may request an original certification from the AART or NMTCB verifying that you are a graduate of an educational program approved by the ARRT or NMTCB. Such certification must be sent directly from the above agency to this office.

Note: For radiographers and radiation therapists applicants, if you choose this option, please note the certification from the ARRT must also include the score/verification of your national certification examination. For nuclear medicine technologists applicants, you must use the "Nuclear Medicine Technologist Verification of Certification" form on page (11) of this application.

Endorsement Candidates

- Verification of licensure sent directly from other state(s) boards in which applicant holds or has held a license to the Rhode Island Department of Health.

Rules and Regulations/Laws

The "Rules and Regulations for the Licensure of Radiographers, Nuclear Medicine Technologists and Radiation Therapists" can be obtained at the following web site:

http://www.rules.state.ri.us/rules/released/pdf/DOH/DOH_279_.pdf

Title 5, Chapter 68, entitled: Board of Radiologic Technology can be downloaded at the following web site:

http://www.rilin.state.ri.us/statutes/title5/5-68/INDEX.HTM

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), and the Rhode Island Board of Radiologic Technology.

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

Please allow a minimum of 4-6 weeks for the entire licensure process to be completed. If you have malpractice criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The Board may be emailed an address change. The email address is located at the following web site.

http://www.health.ri.gov/hsr/professions/rad_tech.php

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:

www.health.ri.gov/hsr/professions/license.php

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-2837.

INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application (pages 5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.

2. Make check or money order (in U.S. funds only) for the application fee of **$90.00** payable to **Rhode Island General Treasurer** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NON-REFUNDABLE .

3. Affix a recent **2 X 2 photo** of yourself in the space provided.

4. A completed official transcript **sent directly** from the accredited school of **Radiologic Technology** to the Board of Radiologic Technology. No student copies will be accepted. *Please Note:* If the ARRT or the NMTCB verifies that you are a graduate of a program approved by the ARRT or NMTCB, you are not required to submit transcripts.

5. Examination scores/cerification **sent directly** from the **ARRT or NBTCB** to the Board of Radiologic Technology.

6. **(Endorsement Candidates):** Please send the license verification form on page 10 to all states in which **applicant** holds or has held a license. Be sure to sign and complete the identifying information on the form. HEALTH must receive these verifications **directly** from the licensing authority in each state.

7. Complete the mandatory taxpayer affidavit on page (12).

8. Mail the application and documentation to:

Rhode Island Department of Health
Board of Radiologic Technology, Room 205
3 Capitol Hill
Providence, RI 02908-5097

State of Rhode Island

Board of Radiologic Technology

Application for License as a Radiographer, Nuclear Medicine Technologist or Radiation Therapist

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

Please Refer to "Mandatory Addendum to License Application" on the last page of this application

3. Gender

☐ Male ☐ Female

4. Date and Place of Birth

Month Day 19 Year

City and State; **OR** Province and Country, etc., if NOT U.S.

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code. If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated: Month Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state, or local statute, regulation, or ordinance, or are there any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Radiographer/Nuclear Medicine Technologist/Radiation Therapist in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Radiologic Technology of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant | Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ _____ Notary Seal

Name of Notary (Print, Type or Stamp) | Signature of Notary

_____ _____

Notary No/Commission No. | Commission Expiration Date (MM/DD/YY)

14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the Rhode Island Board application as instructed (pages 5-8).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 13, **"Affidavit of Applicant"**, and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 14, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the: ***"Rhode Island General Treasurer"*** in the amount of **$90.00** and attached it to the upper left-hand corner of the first (Top) page of the application.
- ☐ I have arranged my Board Application materials in the following order.

    1. Fee (attached as instructed).
    2. Board Application (including cover page) and pages 5-8.
    3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] MUST indicate the section for which the information is being reported.]

- ☐ I have mailed the above application materials directly to the Rhode Island Board of Radiologic Technology.

Required Forms

- ☐ I have completed and mailed the following forms as instructed.

    1. Interstate Verification Form(s) - Other State License(s).

Other Documents

- ☐ I have requested a school transcript and my examination score, as instructed.

Substitute forms are not acceptable, copy this form as needed.

Rhode Island Board of Radiologic Technology
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2837

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSURE

I am applying for a license to practice as a Radiographer/Nuclear Medicine Technologist/Radiation Therapist in the State of Rhode Island. The Rhode Island Board of Radiologic Technology requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Radiologic Technology at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth 19

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE Radiologic Technology BOARD

License Status:	Original Date Issued:	Expiration Date:
☐ Active ☐ Inactive ☐ Lapsed ☐ Other (Specify)_____		

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name and State of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Substitute forms are not acceptable, copy this form as needed.

Rhode Island Board of Radiologic Technology
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2837

NUCLEAR MEDICINE TECHNOLOGIST VERIFICATION OF CERTIFICATION FORM

I am applying for a license to practice as a Nuclear Medicine Technologist in the State of Rhode Island. The Rhode Island Board of Radiologic Technology requires that applicants for Rhode Island licensure must have this form verified, signed and sealed by the Nuclear Medicine Technology Certification Board, 2970 Clairmont Road N.E., Suite 610, Atlanta, GA 30329. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Radiologic Technology at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number 19 Date of Birth

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE NUCLEAR MEDICINE TECHNOLOGY CERTIFICATION BOARD

The individual named above has made application to the Rhode Island Department of Health, Board of Radiologic Technology, to become licensed as a Nuclear Medicine Technologist. Rhode Island Rules and Regulations for the licensure of Radiographers, Nuclear Medicine Technologists and Radiation Therapists requires these individuals to obtain verification of certification by the Nuclear Medicine Technology Certification Board. This form is provided for that purpose.

This is to certify that _____ has completed an accredited program in _____

located at _____ became certified as a _____.

Certification Number: _____

Issue Date: _____

Is the certification in good standing (if no, please explain)? ☐ Yes ☐ No

_____

_____

_____

Certification:

Signature of Executive Officer _____ Date _____

Type or Print Name _____

Title _____

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. . These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case #)

☐ I am in state receivership. (Case #)

☐ I have been discharged from bankruptcy. (Case #)

Type of Professional License for which you are applying.

Full Name (Please Print or Type)

Social Security Number

Signature

Phone Number (including area code if not 401)

Date

This form must be completed, signed and attached to your license application for processing.